

## NOTICE FOR ACTIVE EMPLOYEE MEDICAL PROGRAM ONLY: Disclosure of Grandfathered Status

LANS believes this Medical Program for **active employees and their covered family members** is a “grandfathered health plan” under the Affordable Care Act. As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime dollar limits on essential benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the employer or to the Plan Administrator. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). This Web site has a table summarizing which protections do and do not apply to grandfathered health plans.

# Summary of Benefits: CDHP

CDHP Cost-Sharing: Annual Deductible, Out-of-Pocket Limits; and Health Reimbursement Account (HRA) Funds	Member's Share of Covered Charges	
	Preferred Provider (PPO) (In-Network) <sup>1,2</sup>	Nonpreferred Provider (Out-of-Network) <sup>1,2</sup>
<b>Calendar Year Deductible:</b> Family deductible is an aggregate of two times the Individual amount and may be met by two or more family members. <sup>1</sup>	\$1500/Individual \$2250/Employee + Adult <b>OR</b> \$2250/Employee + Child(ren) \$3000/Family	
<b>Calendar Year Out-of-Pocket Limit:</b> Includes coinsurance only - does not include residential treatment center copayments or deductible. Family limit may be met by two or more family members. <sup>2</sup>	Individual - \$2750 Employee + Adult - \$4125 Employee + Child(ren) - \$4125 Family - \$5500	Individual - \$8500 Employee + Adult - \$12,750 Employee + Child(ren) - \$12,750 Family - \$17000
<b>Lifetime Maximum Benefit Limit</b> (per member)	Unlimited	Unlimited
<b>Health Reimbursement Account (HRA):</b> Used to offset the Medical Program deductible, copayments, and coinsurance. If you do not use all HRA funds during a calendar year, the remaining amount will roll over to the following year, for up to a three-year cap on rolled over dollars.	Individual - \$750 per calendar year Employee + Adult - \$1125 per calendar year Employee + Child(ren) - \$1125 per calendar year Family - \$1500 per calendar year	

**HRA-Only Medical Expenses:** The following expenses are payable only by using HRA funds: qualified medical expenses per Section 213(d) of Internal Revenue Code that are not covered under the Medical Program; smoking cessation or weight loss programs; difference in cost between a brand-name and a generic drug; COBRA premiums.

Active EE/Retiree CDHP Medical Program Covered Services and Limitations	Member's Share of Covered Charges	
	Preferred Provider (PPO) (In-Network) <sup>1,2</sup>	Nonpreferred Provider (Out-of-Network) <sup>1,2</sup>
<b>Office Visit/Exam Charge</b>	10% after deductible	40% after deductible
Family Planning (including devices, insertion, Depo-Provera, etc.)	10% after deductible	40% after deductible
Allergy Injections	No copay ( <i>deductible waived</i> )	40% after deductible
Allergy Care (such as allergy testing; extract preparation)	10% after deductible	40% after deductible
Therapeutic Injections; Office Surgery and Supplies	10% after deductible <sup>4</sup>	40% after deductible <sup>4</sup>
Lab, X-Ray, and Other Diagnostic Tests (nonroutine/nonpreventive)	10% after deductible <sup>4</sup>	40% after deductible <sup>4</sup>
Nutritional Counseling (3 sessions/life for certain conditions)	10% after deductible	40% after deductible
<b>Routine/Preventive Well-Baby Care (Through Age 2):</b> Routine check-ups; routine screenings; routine laboratory tests; immunizations	No Copay ( <i>deductible waived</i> )	40% ( <i>deductible waived</i> )
<b>Routine/Preventive Well-Child Care (Ages 3-18):</b> Routine physicals and exams, well-child care; immunizations, routine vision/hearing screenings	No Copay ( <i>deductible waived</i> )	40% after deductible
<b>Routine/Preventive Adult Care (Ages 19 and Older):</b> Routine adult physicals and gynecological exams; colonoscopies, immunizations	No Copay ( <i>deductible waived</i> )	40% after deductible
<b>Routine/Preventive Lab, X-Ray, and Other Testing (Ages 3 and Older):</b> Including Pap tests, mammograms, cholesterol tests, urinalysis, EKGs	No Copay ( <i>deductible waived</i> )	40% after deductible
<b>OTHER MEDICAL/SURGICAL SERVICES</b>		
<b>Acupuncture</b> (limited to 20 visits/year)	10% after deductible	40% after deductible
<b>Ambulance: Emergency Transport</b> (Air/ground ambulance, as needed)	10% after deductible <sup>3</sup>	
<b>Ambulance: Nonemergency Ground Transfer</b> (between facilities)	10% after deductible <sup>4</sup>	
<b>Ambulance: Nonemergency Air Transfer</b> (between facilities)	10% after deductible <sup>4</sup>	40% after deductible <sup>4</sup>
<b>Emergency Room Visit</b> ( <i>emergency condition only; including facility, physician and other professional provider charges</i> )	10% after deductible <sup>3</sup>	

This is a Preferred Provider (PPO) Medical Program. This means that if you obtain services from an out-of-network (non-PPO) provider, your share of the bill is greatly increased. It is YOUR responsibility to determine if a provider is in the national/worldwide BCBS PPO network or not.

Active EE/Retiree CDHP Medical Program Covered Services and Limitations (continued)	Preferred Provider (PPO) (In-Network) <sup>1,2</sup>	Nonpreferred Provider (Out-of-Network) <sup>1,2</sup>
<b>Cancer/Congenital Heart Disease Care</b> (Blue Distinction programs only include a lodging per diem benefit of \$50 per person, or \$100 per day for 2-3 persons. Travel and the above per diem allowances combined are limited to \$10,000 per lifetime for each program utilized. If program is not used, benefits are same as for any other service, based on place of treatment, provider contract, and type of service.)	10% after deductible <sup>4,5</sup>	40% after deductible <sup>4,5</sup>
<b>Cardiac and Pulmonary Rehabilitation, Outpatient/Office</b>	10% after deductible <sup>4</sup>	40% after deductible <sup>4</sup>
<b>Dental/Facial Accident<sup>3</sup>, Oral Surgery, TMJ/CMJ Services</b> (for limited, non-dental medical conditions; see a benefit booklet for details)	10% after deductible <sup>4</sup>	40% after deductible <sup>3,4</sup>
<b>Hearing-Related Services</b> - Office exams and evaluations; cochlear implant; auditory testing - Hearing aid services (maximum total benefit of \$2,200 during 36-month period, including fitting of hearing aid and ear molds)	10% after deductible	40% after deductible
<b>Home Health Care/Home I.V. Services</b> (Private duty nursing <b>not</b> covered; care must be from a licensed home health care agency) Home health care agency services and home I.V. services (Out-of-network limited to 100 visits/calendar year)	10% after deductible <sup>4</sup>	40% after deductible <sup>4</sup>
<b>Hospice Services</b> including bereavement counseling when such services are provided by hospice (Respite care limited to 10 days for each 6-month benefit period.)	10% after deductible <sup>4</sup>	40% after deductible <sup>4</sup>
<b>Hospital/Other Facility: Inpatient</b>		
- <b>Medical/Surgical Acute Care, Observation, Medical Detox, and Extended Stay (Nonroutine) for Covered Newborn:</b> Room, Board, Covered Ancillaries	10% after deductible <sup>5</sup>	40% after deductible <sup>5</sup>
- <b>Maternity Hospital Fees and Birthing Center</b>	10% (deductible waived) <sup>5</sup>	40% after deductible <sup>5</sup>
- <b>Skilled Nursing Facility and Inpatient Physical Rehabilitation</b> (max. 100 days per calendar year for preferred and nonpreferred combined; in addition, nonpreferred services cannot exceed 70 days per calendar year)	10% after deductible <sup>5</sup>	40% after deductible <sup>5</sup>
- <b>Inpatient Physician's Medical Visit or Consultation</b>	No copay (deductible waived)	40% after deductible
- <b>Inpatient Surgeon, Anesthesiologist, Radiologist, Pathologist, and Assistant Surgeon</b>	10% after deductible	40% after deductible
<b>Hospital/Other Facility: Outpatient</b> (Includes covered services, whether billed by facility or professional provider, including surgery, diagnostic tests, chemotherapy, dialysis, and radiation treatment.)	10% after deductible (deductible waived for maternity care) <sup>4</sup>	40% after deductible <sup>4</sup>
<b>Lab, X-Ray, and Other Diagnostic Tests (nonroutine/nonpreventive)</b> Including MRI, CT Scans, and PET Scans; Sleep Studies; EKGs, etc. - Office or Freestanding/Independent Facility; Outpatient Hospital	10% after deductible (deductible waived for maternity care) <sup>4</sup>	40% after deductible <sup>4</sup>
<b>Maternity Care</b> - Initial visit to confirm pregnancy - All other expenses	10% after deductible 10% (deductible waived) <sup>5</sup>	40% after deductible <sup>5</sup>
<b>Short-Term Rehabilitation, Outpatient and Office</b> (Includes outpatient and office physical, occupational, and speech therapy services, each of which is limited to 20 visits/calendar year. Speech therapy is limited to specified medical conditions; see a benefit booklet for details.)	10% after deductible <sup>4</sup>	40% after deductible <sup>4</sup>
<b>Spinal/Osteopathic Manipulation</b> (Max. 20 visits/calendar year)	10% after deductible	40% after deductible
<b>Supplies, Durable Medical Equipment, Prosthetics, Orthotics</b> (Support hose up to 6/year. Mastectomy bras limited to 3/year. For diabetic supplies such as needles, test strips, glucagon, etc., see drug plan provision.)	10% after deductible <sup>4,6</sup>	40% after deductible <sup>4,6</sup>
<b>Surgery: Outpatient, Ambulatory Surgery Center, or Office</b> (including related surgeon, pathologist, radiologist, etc.)	10% after deductible <sup>4</sup>	40% after deductible <sup>4</sup>
<b>Therapy: Chemotherapy, Dialysis, and Radiation</b>	10% after deductible <sup>4,5</sup>	40% after deductible <sup>4,5</sup>
<b>Transplant Services:</b> Limitations apply to donor charges and travel and lodging. Must be received at a facility that contracts with BCBSNM or with the national BCBS transplant network.	10% after deductible <sup>4,5</sup>	No benefit
<b>Urgent Care Facility</b>	10% after deductible	40% after deductible

See footnotes on next page

Active EE/Retiree CDHP Medical Program Covered Services and Limitations (continued)		Preferred Provider (PPO) (In-Network) <sup>1,2</sup>	Nonpreferred Provider (Out-of-Network) <sup>1,2</sup>
<b>Travel and Lodging:</b> Benefits are available when these services are related to case-managed Cancer Services or Congenital Heart Disease if patient is receiving treatment from a Blue Distinction Center for Specialty Care or case-managed transplants (excluding cornea). Travel of more than 50 miles must be necessary in order to be eligible for coverage under this provision. For <b>each</b> of the three benefit programs, the benefits are as follows:			
Travel to and from health care facility plus per diem payments listed below		\$10,000/lifetime after deductible <sup>4</sup>	
Lodging <b>per diem</b> for patient and/or companion(s)		\$50/individual or \$100 for 2-3 persons after deductible <sup>4</sup>	
<b>BEHAVIORAL HEALTH: Mental Health and Chemical Dependency</b>			
<b>Mental Health Services</b> - Office, Outpatient, Intensive Outpatient Programs (IOP); Inpatient and/or Partial Hospitalization		10% after deductible (no copay for inpatient physician) <sup>4,5</sup>	40% after deductible <sup>4,5</sup>
<b>Chemical Dependency Rehabilitation</b> - Office, Outpatient, Intensive Outpatient Programs (IOP); Outpatient/Suboxone Treatment; Inpatient and/or Partial Hospitalization - Residential Treatment Center (max. <b>130 days</b> /lifetime), including physician		10% after deductible (no copay for inpatient physician) <sup>4,5</sup> \$250 + 20% after deductible <sup>4,5,7</sup>	40% after deductible <sup>4,5</sup> \$250 + 40% after deductible <sup>4,5,7</sup>
<b>DRUG PLAN: Prescription Drugs, Insulin, Diabetic Supplies, Nutritional Products, Specified Vaccines<sup>8</sup></b>			
Enteral nutritional products, compounded medications, special medical foods, and certain other drugs require preauthorization or benefits will be denied.	Generic Drug	Brand-Name Drug <sup>8</sup>	
		No generic available	Generic available <sup>8</sup>
<b>Retail Pharmacy/Specialty Pharmacy Programs</b> (up to a 30-day supply or 180 units, whichever is less; benefits include flu, pneumococcal, and Zostavax vaccines for which no copayment is required)	You pay 20% of covered charges after deductible		
<b>Mail-Order Program</b> (up to a 90-day supply or 540 units, whichever is less)			
<b>Nonprescription Enteral Nutritional Products and Special Medical Foods</b> (up to a 30-day supply per 30-day period; requires preauthorization)	You pay 20% of covered charges after deductible		

**FOOTNOTES:**

- 1 All services are subject to deductible unless otherwise indicated in the *Summary of Benefits* (i.e., "deductible waived"). When applicable, the deductible must be met before benefit payments are made.
- 2 After you reach an out-of-pocket limit, the Plan pays 100 percent of most of your covered Preferred Provider (In-Network) or Nonpreferred Provider (Out-of-Network) charges, whichever is applicable, for the rest of the calendar year (excludes copayments for residential treatment and deductible). Items covered under the drug plan are subject to the Preferred Provider (In-Network) out-of-pocket limit. Preferred Provider (In-Network) expenses do **not** cross-apply to the Nonpreferred Provider (Out-of-Network) limit or vice versa.
- 3 Initial treatment of a medical emergency is paid at the Preferred Provider (In-Network) benefit level. Follow-up treatment and treatment that is not for an emergency is paid at the Nonpreferred Provider (Out-of-Network) level.
- 4 Certain services are **not covered** if preauthorization is not obtained from BCBSNM (or the BCBSNM Behavioral Health Unit). A list of services requiring preauthorization and a description of when obtaining preauthorization is **your** responsibility is in Section 4 of the CDHP Medical Program benefit booklet. Some services may require a written request for preauthorization in order to be covered. (Nonemergency ambulance services are covered **only** when it is medically necessary to transfer the patient from one facility to another.) See Section 4 in the benefit booklet for details.
- 5 Preauthorization is required for inpatient admissions. You pay a **\$300 penalty** for covered inpatient facility services if preauthorization is your responsibility and is not obtained. Some services, such as transplants and physical rehabilitation, require additional preauthorization. If you do not receive preauthorization for these individually identified procedures and services, benefits for any related admissions will be denied. (The \$300 penalty will not apply in such cases.)
- 6 Rental benefits for medical equipment and other items will not exceed purchase price of a new unit.
- 7 Extended care facilities (such as nursing homes and residential treatment centers) are excluded from coverage. However, LANS has authorized the Claims Administrator to approve, when used as a cost-effective alternative to inpatient hospitalization, up to **130 days** of residential treatment center services for patients being treated for chemical dependency. This is a lifetime maximum that accrues from Medical Program to Medical Program and is the only exception that can be made to the extended care facility exclusion.
- 8 Prescription drugs must be purchased at a pharmacy that participates in the Retail Pharmacy/Specialty Pharmacy Drug or Mail-Order Service Programs. (BCBSNM has contracted with a separate program for administration of your prescription drug benefits.) If you require a brand-name drug for which there is a generic equivalent, you will pay the difference in cost between the brand-name drug and the generic drug, plus the deductible (if not met) and the 20 percent coinsurance amount.

**NOTE: Deductibles, copayments, and coinsurance percentages are applied to BCBSNM's covered charges, which may be less than the provider's billed charges. Preferred Providers will not charge you the difference between the covered charge and the billed charge for covered services; Nonpreferred Providers may.**